the code in the column labeled (A). If the resident has an amputation on one side of the body, use Code "1", Limitation on one side of the body. If there are bilateral amputations, use code "2", Limitation on both sides of the body.

0. **No limitation** — Resident has full function range of motion on the right and left side.

1. **Limitation on one side of the body (either right or left side).**

2. **Limitation on both sides of the body.**

Example of Coding for
(A) Limitation in Range of Motion

Mr. O was admitted to the nursing home for rehabilitation following right knee surgery. His right leg is in an immobilizer. With the exception of his right leg, Mr. O has full active range of motion in all other areas.

Coding (A)

Neck	0
Arm	0
Hand	0
Leg	1
Foot	0
Other	0

(B) Loss of voluntary movement.

Definition: **Loss of voluntary movement** — Impairment in purposeful (intentional) functional movement. This category refers to a range of impairments exhibited when a resident tries to perform a task and includes deficits such as incoordination, tremors, spasms, muscular rigidity, "freezing", choreiform movements (jerking) as well as lack of initiation of movement. Impairments in voluntary movement are often due to injury or disease of muscles, bones, nerves, spinal cord or the brain and can place a resident at risk for functional disability and injury.

Process: While performing the assessment of range of motion in item G4(A) above, observe the resident for impairment(s) in purposeful movement on each side of the resident's body.

Coding: For each body part, code the appropriate response for the resident's function during the past seven days. Enter the code in the column labelled (B). If the body part is missing on one side (e.g., left above knee amputation), code "1",

Partial loss of voluntary movement. If missing bilaterally, code "2", Full loss of voluntary movement.

0. **No loss of voluntary movement** — Resident moves body part to complete the required task. Movements are smooth and coordinated.

1. **Partial loss of voluntary movement** — Resident is able to initiate and complete the required task but movements are slow, spastic, uncoordinated, rigid, choreiform frozen, etc. on one or both sides.

2. **Full loss of voluntary movement** — Resident is not able to initiate the required task. There is no voluntary movement on either side.

Example of Function Limitation

Mrs. X is a diabetic who sustained a CVA 2 months ago. She can only turn her head slightly from side to side and tip her head towards each shoulder (limited neck range of motion). She can perform all arm, hand, and leg motions on the right side, with smooth coordinated movements. She is unable to move her left side (limited arm, hand, and leg motion) as she has a flaccid left hemiparesis. She is able to extend her legs flat on the bed. She has no feet. She has no other limitations.

	Coding	
	(A) Limitation in Range of Motion	(B) Loss of Voluntary Movement
a. Neck	2	0
b. Arm	1	1
c. Hand	1	1
d. Leg	1	1
e. Foot	2	2
f. Other	0	0

5. Modes of Locomotion

Intent: To record the type(s) of appliances, devices, or personal assistance the resident used for locomotion (on and off unit).

Definition: **Cane/walker/crutch** — Also check this item in those instances where the resident walks by pushing a wheelchair for support.

Wheeled self — Includes using a hand-propelled or motorized wheelchair, as long as the resident takes responsibility for self-mobility, even for part of the time.

Other person wheeled — Another person pushed the resident in a wheelchair.

Wheelchair primary mode of locomotion — Even if resident walks some of the time, he or she is primarily dependent on a wheelchair to get around. The wheelchair may be motorized, self-propelled, or pushed by another person.

Coding: Check all that apply during the last 7 days. If no appliances or assistive devices were used, check *NONE OF ABOVE.*

6. Modes of Transfer

Intent: To record the type(s) of appliances or assistive devices the resident used for transferring in and out of bed or chair, and for bed mobility.

Definition: **Bedfast all or most of the time** — Resident is in bed or in a recliner in own room for 22 hours or more per day. This definition also includes residents who are primarily bedfast but have bathroom privileges. For care planning purposes this information is useful for identifying residents who are at risk of developing physical and functional problems associated with restricted mobility, as well as cognitive, mood, and behavior impairment related to social isolation. **Code this item when it was true on at least 4 of the last 7 days.**

Bed rail(s) used for bed mobility or transfer — Refers to any type of side rail(s) attached to the bed USED by the resident as a means of support to facilitate turning and repositioning in bed, as well as for getting in and out of bed. **Do not check this item if resident did not use rails for this purpose.**

Lifted manually — The resident was completely lifted by one or more persons.

Lifted mechanically — The resident was lifted by a mechanical device (e.g., Hoyer lift). Does not include a bath lift.

Transfer Aid — Includes devices such as slide boards, trapezes, canes, walkers, braces and other assistive devices.

Coding: Check all that apply. If none of these items apply, check *NONE of ABOVE.*

7. Task Segmentation

Intent: To identify residents who are more involved and independent in personal care tasks (such as eating, bathing, grooming, dressing) because they have received help in breaking tasks down into smaller steps. Some residents become overwhelmed and anxious when there are expectations for greater independence and they are no longer able to perform the steps necessary to complete an ADL activity. Such residents are at great risk for becoming dependent on others unless activities are made easier for them to manage by task segmentation. These residents usually have some deficits in memory, thinking, or paying attention to the task consequent to problems such as dementia, head injury, CVA, or depression. Other residents receive task segmentation care because of body-control problems, poor stamina, or other physical difficulties that limit self-performance.

Definition: **Task segmentation** provides the resident with directions — such as verbal cues, physical cues, or verbal and physical cues — for performing each constituent step in an ADL activity.

Verbal cueing involves giving a verbal direction to complete the first step in a task, and once the step is accomplished, giving another verbal direction to complete the next step. Verbal encouragement, praise, and feedback for the resident's successful completion of the steps are usually given by the direct care staff person prior to providing the next verbal cue. For example, "That looks good. Now put on this skirt."

Physical cueing involves giving the resident an object as a reminder of what needs to be done — e.g., handing the resident some toilet paper as a cue to wipe self, or placing an item from a food tray in front of the resident and handing him or her a fork as a cue to eat the item.

Physical and verbal cueing involves use of objects and words to stimulate action — e.g., giving the resident one item of clothing at a time and saying "Put this shirt on," which is less confusing to a cognitively impaired resident than putting all clothing items before him or her and saying "Get dressed."

Examples	
Task Segmentation	**No Task Segmentation**
• When handed a soapy face cloth and asked, "Would you please wash your face?", the resident washes her face.	• When a wash basin, a face cloth, a towel, and various grooming supplies are placed before the resident, the resident becomes overwhelmed.
• When a nurse assistant sets a mirror in front of the resident, and hands him a brush, the resident brushes his hair.	• When a nurse assistant places the resident's clothes for the day on the bed and says, "Get dressed," the resident becomes confused and is unable to dress self.
• When the nurse assistant hands the resident a sock and says "Put this sock on this foot" and upon completion of the step hands the resident another sock and says "Put this sock on this foot," the resident dons his socks.	• When a tray containing an entire meal and several different utensils are placed before the resident on a table, the resident becomes confused and is unable to eat by herself.
• When single food items and only one utensil are presented to the resident in succession, the resident eats independently. • When a nurse assistant gives verbal directions for each step in transferring from a wheelchair (e.g., "Lock the brakes... Hold onto the arms of the chair and push yourself up... Hold onto your walker with both hands like this [demonstrates]"), the resident succeeds in transferring himself from a seated to a standing position.	• When a nurse assistant lifts a resident from a sitting to a standing position and does not involve the resident in the process of self-care in the activity, the resident becomes more physically dependent on the nurse assistant.
For all above examples, **Code "1" for Yes.**	For all above examples, **Code "0" for No.**

Process: Ask the nurse assistant to think about how the resident completes activities of daily living, or ways the nurse assistant helped the resident complete an activity of daily living over the last seven days. Specifically: Did the nurse assistant break the ADL activity into subtasks (smaller steps) so that the resident could perform them? Did this occur in the last seven days?

Coding: Code "0" if task segmentation was not done. Code "1" if ADLs were broken into a series of subtasks so that resident could perform them.

8. ADL Functional Rehabilitation Potential

Intent: To describe beliefs and characteristics related to the resident's functional status that may indicate he or she has the capacity for greater independence and involvement in self-care in at least some ADL areas. Even if highly independent in an activity, the resident may believe he or she can do better (e.g., walk longer distances, shower independently).

Process: Ask if the resident thinks he or she could be more self-sufficient given more time. Listen to and record what the resident believes, even if it appears unrealistic. Also, as a clue to whether the resident might do better all the time, ask if his or her ability to perform ADLs varies from time to time, or if ADL function or joint range of motion has declined or improved in the last three months.

Ask direct care staff (e.g., nurse assistants on all shifts) who routinely care for the resident if they think he or she is capable of greater independence, or if the resident's performance in ADLs varies from time to time. Ask if ADL function or range of motion of joints declined or improved in the last three months. You may need to prompt staff to consider such factors as:

- Has self-performance in any ADL varied over the last week (e.g., the resident usually requires two-person assistance but on one day transferred out of bed with assistance of one person)?

- Has resident's performance varied during the day (e.g., more involved and independent in the afternoon than in the morning)?

- Was the resident so slow in performing some activities that staff members intervened and performed the task or activity? Is the resident capable of increased self-performance when given more time? - OR - Is the resident capable of increased self-performance when tasks are broken into manageable steps?

- Does the resident tire noticeably during most days?
- Does the resident avoid an ADL activity even though physically or cognitively capable (e.g., refuses to walk alone for fear of falling, demands that others attend to personal care because they do it better)?
- Has the resident's performance in any ADL improved?

Coding: Check all that apply. If none of these items apply check *NONE OF ABOVE.*

Examples

Mr. N, who is cognitively impaired, receives limited physical assistance in locomotion for safety purposes. However, he believes he is capable of walking alone and often gets up and walks by himself when staff aren't looking. **Check "a" (Resident believes he/she capable of increased independence).**

The nurse assistant who totally feeds Mrs. W has noticed in the past week that Mrs. W has made several attempts to pick up finger foods. She believes Mrs. W could become more independent in eating if she received close supervision (cueing) in a small group for restorative care in eating. **Check "b" (Direct care staff believes resident is capable of increased independence).**

Mrs. Y has demonstrated the ability to get dressed, but has missed breakfast on several occasions because she was slow getting organized. Therefore, every morning her nurse assistant physically helped her to dress so that she would be ready for breakfast. **Check "c" (Resident able to perform task but is very slow).**

Mrs. F remained continent during day shifts while receiving supervision in toileting. During the evening and night shifts she was incontinent because she was not helped out of bed to the toilet room. After incontinence episodes, direct-care staff provided total help in hygiene. **Check "d" (Difference in ADL self-performance or ADL support, comparing mornings to evenings).**

Mr. K has hemiplegia secondary to a CVA. He receives extensive assistance in bed mobility transfer, dressing, toilet use, personal hygiene and eating. He is totally dependent in locomotion (wheelchair). Whenever he has tried to do more for himself he has experienced chest pain and shortness of breath. Both Mr. K and direct care staff believe that he is involved in self-care as much as he is physically able. **Check "e" (*NONE OF ABOVE*).**

9. Change in ADL Function

Intent: To document any changes occurring in the resident's overall ADL self-performance, as compared to status of 90 days ago (or since last assessment if less than 90 days ago). These include, but are not limited to, changes in the resident's level of involvement in ADL activities as well as the amount and the type of support received by staff. If the resident is a new admission to the facility, this item includes changes during the period prior to admission.

Process: Review the record for indications of a change. Consult with the resident and direct care staff. Review Section G from the last assessment and compare these findings with current findings. For new residents, consult with the primary family caregiver.

Coding: Code "0" if there has been no change. Code "1" if the resident's ADL function has improved. Code "2" if the resident's function has deteriorated. You may find that some ADLs have improved, some deteriorated, and others remain unchanged. You must weigh all of the information and make an overall clinical judgment (e.g., in general, the resident's ADL function has...).

Examples

Dr. B had been highly involved in self-care in most ADL activities. Seven weeks ago he slipped, fell, and bruised his right wrist. For several weeks he received more extensive assistance with dressing, grooming, and eating. However, in the last three weeks he is functioning at the same level of involvement in ADLs as before the fall. **Code "0" for No change.**

Ms. A participated in a structured feeding group during the past six weeks. With lots of encouragement and supervision from the group leader, she has progressed from requiring extensive assistance to feeding herself under staff supervision. Her performance in other ADLs remains unchanged. **Code "1" for Improved.**

Since fracturing her left hip three weeks ago, Mrs. Z receives more weight bearing help with transfers, locomotion, dressing, toileting, personal hygiene, and bathing. However, she has made strides in OT and PT. Her improvement in self-care has been steady although she still has a long way to go to reach her Self-Performance level of 90 days ago. **Code "2" for Deteriorated.**

(continued on next page)

Examples
(continued)

Mr. L's favorite nurse (Miss McC) transferred to another unit 30 days ago. Although he says he's happy for her, he has become more passive and withdrawn. He no longer dresses himself in a suit and tie. His personal hygiene habits have deteriorated and he now must be frequently coaxed to shave and wash himself and comb his hair. Because he now wears stained clothing, staff have started to select and set out his clothes each day. Despite these losses, Mr. L is now somewhat more self-sufficient in locomotion, making twice-a-week trips to see Miss McC on her new unit. **Code "2" for Deteriorated.** The ***rationale*** for the coding decision is that although some improvement is noted in one ADL activity (locomotion) it only occurs twice weekly. In general, Mr. L has deteriorated in his self-care performance in two ADL activities (dressing and personal hygiene) that require multiple daily tasks.

During a Significant Change assessment for severe mood distress, Mrs. M was found to be more dependent on others for physical assistance in personal hygiene, dressing and toileting. She also received more coaxing and encouragement to eat. These changes represented less involvement in self-care since the last assessment two months ago. **Code "2" for Deteriorated.**

SECTION H.
CONTINENCE IN LAST 14 DAYS

1. Continence Self-Control Categories

Note: This section differs from the other ADL assessment items in that the time period for review has been extended to 14 days. Research has shown that 14 days are the minimum required to obtain an accurate picture of bowel continence patterns. For the sake of consistency, both bowel continence and bladder continence are evaluated over 14 days.

Intent: To determine and record the resident's pattern of bladder and bowel continence (control) over the last 14 days.

Definition: **Bladder and Bowel Continence** — Refers to control of urinary bladder function and/or bowel movement. This item describes the resident's bowel and bladder continence pattern even with scheduled toileting plans, continence training programs, or appliances. It does not refer to the resident's ability to toilet self — e.g., a resident can receive extensive assistance in toileting and yet

4. **Incontinent** — Has inadequate control. Bladder incontinent episodes occur multiple times daily; Bowel incontinent is all (or almost all) of the time.

Coding: Choose one response to code level of bladder continence and one response to code level of bowel continence for the resident over the last 14 days.

Code for the resident's actual bladder and bowel continence pattern — i.e., the frequency with which the resident is wet and dry during the 14 day assessment period. Do not record the level of control that the resident might have achieved under optimal circumstances.

For bladder incontinence, the difference between a code of "3" (Frequently Incontinent) and "4" (Incontinent) is determined by the presence ("3") or absence ("4") of any bladder control.

Examples of Bladder Continence Coding

Mr. Q was taken to the toilet after every meal, before bed, and once during the night. He was never found wet and is considered continent. **Code "0" for "Continent" — Bladder.**

Mr. R had an indwelling catheter in place during the entire 14 day assessment period. He was never found wet and is considered continent. **Code "0" for "Continent" — Bladder.**

Although she is generally continent of urine, every once in a while (about once in 2 weeks) Mrs. T doesn't make it to the bathroom to urinate in time after receiving her daily diuretic pill. **Code "1" for "Usually Continent" — Bladder.**

Mrs. A has less than daily episodes of urinary incontinence, particularly late in the day when she is tired. **Code "2" for "Occasionally Incontinent" — Bladder.**

Mr. S is comatose. He wears an external (condom) catheter to protect his skin from contact with urine. This catheter has been difficult for staff to manage as it keeps slipping off. They have tried several different brands without success. During the last 14 days Mr. S has been found wet at least twice daily on the day shift. **Code "3" for "Frequently Incontinent" — Bladder.**

Mrs. U is terminally ill with end-stage Alzheimer's disease. She is very frail and has stiff, painful contractures of all extremities. She is primarily bedfast on a special water mattress, and is turned and re-positioned hourly for comfort. She is not toileted and is incontinent of urine for all episodes. **Code "4" for Incontinent" — Bladder.**

2. Bowel Elimination Pattern

Intent: To record the effectiveness of resident's bowel function.

Definition: **Bowel elimination pattern regular** — Resident has at least one movement every three days.

Constipation — Resident passes two or fewer bowel movements per week, or strains more than one out of four times when having a bowel movement.

Diarrhea — Frequent elimination of watery stools from any etiology (e.g., diet, viral or bacterial infection).

Fecal impaction — The presence of hard stool upon digital rectal exam. Fecal impaction may also be present if stool is seen on abdominal x-ray in the sigmoid colon or higher, even with a negative digital exam or documentation in the clinical record of daily bowel movement.

Process: Ask the resident. Examine, if necessary. Review the clinical record, particularly any documentation flow sheets of bowel elimination patterns. Ask direct care staff (e.g., nurse assistants from all shifts).

Coding: Check all that apply in the last 14 days. If no items apply, check *NONE OF ABOVE*.

3. Appliances and Programs

Definition: **Any scheduled toileting plan** — A plan whereby staff members at scheduled times each day either take the resident to the toilet room, or give the resident a urinal, or remind the resident to go to the toilet. Includes habit training and/or prompted voiding.

Bladder retraining program — A retraining program where the resident is taught to consciously delay urinating (voiding) or resist the urgency to void. Residents are encouraged to void on a schedule rather than according to their urge to void. This form of training is used to manage urinary incontinence due to bladder instability.

External (condom) catheter — A urinary collection appliance worn over the penis.

Indwelling catheter — A catheter that is maintained within the bladder for the purpose of continuous drainage of urine. Includes catheters inserted through the urethra or by supra-pubic incision.

Intermittent catheter — A catheter that is used periodically for draining urine from the bladder. This type of catheter is usually removed immediately after the bladder has been emptied. Includes intermittent catheterization whether performed by a licensed professional or by the resident. Catheterization may occur as a one-time event (e.g., to obtain a sterile specimen) or as part of a bladder emptying program (e.g., every shift in a resident with an underactive or acontractile bladder muscle).

Did not use toilet room/commode/urinal — Resident never used any of these items during the last 14 days, nor used a bed pan.

Pads/brief used — Any type of absorbent, disposable or reusable undergarment or item, whether worn by the resident (e.g., diaper, adult brief) or placed on the bed or chair for protection from incontinence. Does not include the routine use of pads on beds when a resident is never or rarely incontinent.

Enemas/irrigation — Any type of enema or bowel irrigation, including ostomy irrigations.

Ostomy present — Any type of ostomy of the gastrointestinal or genitourinary tract.

Process: Check the clinical record. Consult with nurse assistant and the resident. Be sure to ask about any items that are usually hidden from view because they are worn under street clothing (e.g., pads or briefs).

Coding: Check all that apply. If none of the items apply, check *NONE OF ABOVE.*

4. Change in Urinary Continence

Intent: To document changes in the resident's urinary continence status as compared to 90 days ago (or since last assessment if less than 90 days ago), including any changes in self-control categories, appliances, or programs. If the resident is a new admission to the facility, this item includes changes during the period prior to admission.

Process: Review the resident's clinical record and Bladder Continence patterns as recorded in the last assessment (if available). Validate findings with the

resident and direct care staff on all shifts. For new residents, consult with the primary family caregiver.

Coding: Code "0" for No change, "1" for Improvement, or "2" for Deteriorated. A resident who was incontinent 90 days ago who is now continent by virtue of a catheter should be coded as "1", Improved. See fourth example in the box below.

Examples of Change in Urinary Continence

During an outbreak of gastroenteritis at the nursing home six weeks ago, Mrs. L, who is usually continent, became totally incontinent of bladder and bowel. This problem lasted only two weeks and she has been continent for the last month. **Code "0" for No change.**

Dr. R had prostate surgery three months ago. Prior to surgery, he was frequently incontinent. Upon returning from the hospital, his indwelling catheter was discontinued. Although he initially experienced incontinence, he now remains dry with only occasional incontinence. He sings the praises of surgery to his peers. **Code "1" for Improved.**

Mrs. B is a new admission. Both she and her daughter report that she has never been incontinent of urine. By her third day of residency, her urinary incontinence became evident, especially at night. **Code "2" for Deteriorated.**

Two weeks ago Mr. K returned from the hospital following plastic surgery for a pressure ulcer. Prior to hospital admission, Mr. K was totally incontinent of urine. He is now continent with an indwelling catheter in place. **Code "1" for Improved.** ***Rationale:*** Although one could perceive that Mr. K had "deteriorated" because he now has a catheter for bladder control, remember that the MDS definition for bladder continence states "Control of bladder function with appliances (e.g., foley) or continence programs, if employed."

SECTION I.
DISEASE DIAGNOSES

Intent: To document the presence of diseases that have a relationship to the resident's current ADL status, cognitive status, mood or behavior status, medical treatments, nursing monitoring or risk of death. In general, these are conditions that drive the current care plan. Do not include conditions that have been resolved or no longer affect the resident's functioning or care plan. In many facilities, clinical staff and physicians neglect to update the list of

resident's "active" diagnoses. There may also be a tendency to continue old diagnoses that are either resolved or no longer relevant to the resident's plan of care. One of the important functions of the MDS assessment is to generate an updated, accurate picture of the resident's health status.

Definition: **Nursing monitoring** — Includes clinical monitoring by a licensed nurse (e.g., serial blood pressure evaluations, medication management, etc.)

1. Diseases

Definition: **Diabetes mellitus** — Includes insulin-dependent diabetes mellitus (IDDM) and diet-controlled diabetes mellitus (NIDDM or AODM).

Cardiac dysrhythmias — Disorder of heart rate or heart rhythm.

Peripheral vascular disease — Vascular disease of the lower extremities that can be of venous and/or arterial origin.

Arthritis — Includes degenerative joint disease (DJD), osteoarthritis (OA), and rheumatoid arthritis (RA). Record more specific forms of arthritis (e.g., Sjogren's syndrome; gouty arthritis) in Item I3 (with ICD-9-CM code).

Hip fracture — Includes any hip fracture that occurred at any time that continues to have a relationship to current status, treatments, monitoring, etc. Hip fracture diagnoses also include femoral neck fractures, fractures of the trochanter, subcapital fractures.

Missing limb (e.g., amputation) — Includes loss of any part of any upper or lower extremity.

Pathological bone fracture — Fracture of any bone due to weakening of the bone, usually as a result of a cancerous process.

Aphasia — A speech or language disorder caused by disease or injury to the brain resulting in difficulty expressing thoughts (i.e., speaking, writing), or understanding spoken or written language.

Cerebral palsy — Paralysis related to developmental brain defects or birth trauma.

Cerebrovascular accident (CVA/Stroke) — A vascular insult to the brain that may be caused by intracranial bleeding, cerebral thromboses, infarcts, emboli.

Dementia other than Alzheimer's — Includes diagnoses of organic brain syndrome (OBS) or chronic brain syndrome (CBS), senility, senile dementia, multi-infarct dementia, and dementia related to neurologic diseases other than Alzheimer's (e.g., Picks, Creutzfeld-Jacob, Huntington's disease, etc.).

Hemiplegia/hemiparesis — Paralysis/partial paralysis (temporary or permanent impairment of sensation, function, motion) of both limbs on one side of the body. Usually caused by cerebral hemorrhage, thrombosis, embolism, or tumor. There must be a diagnosis of hemiplegia or hemiparesis in the resident's record.

Paraplegia — Paralysis (temporary or permanent impairment of sensation, function, motion) of the lower part of the body, including both legs. Usually caused by cerebral hemorrhage, thrombosis, embolism, tumor, or spinal cord injury. There must be a diagnosis of paraplegia in the resident's record.

Quadriplegia — Paralysis (temporary or permanent impairment of sensation, function, motion) of all four limbs. Usually caused by cerebral hemorrhage, thrombosis, embolism, tumor, or spinal cord injury. There must be a diagnosis of quadriplegia in the resident's record.

Transient ischemia attack — A sudden, temporary, inadequate supply of blood to a localized area of the brain. Often recurrent.

Traumatic brain injury — Damage to the brain as a result of physical injury to the head.

Manic depressive (bipolar disease) — Includes documentation of clinical diagnoses of either manic depression or bipolar disorder. "Bipolar disorder" is the current term for manic depressive illness.

Emphysema/COPD — Includes COPD (chronic obstructive pulmonary disease) or COLD (chronic obstructive lung disease), chronic restrictive lung diseases such as asbestosis, and chronic bronchitis.

Allergies — Any hypersensitivity caused by exposure to a particular allergen. Includes agents (natural and artificial) to which the resident is susceptible for an allergic reaction, not only those to which he or she currently reacted to in the last seven days. This item includes allergies to drugs (e.g., aspirin, antibiotics), foods (e.g., eggs, wheat, strawberries, shellfish, milk), environmental substances (e.g., dust, pollen), animals (e.g., dogs, birds, cats), and cleaning products (e.g., soap, laundry detergent), etc. Hypersensitivity reactions include but are not limited to, itchy eyes, runny nose, sneezing, contact dermatitis, etc.

Anemia — Includes anemia of any etiology.

Process: Consult transfer documentation and medical record (including current physician treatment orders and nursing care plans). If the resident was admitted from an acute care or rehabilitation hospital, the discharge forms often list diagnoses and corresponding ICD-9-CM codes that were current during the hospital stay. If these diagnoses are still active, record them on the MDS form. Also, accept statements by the resident that seem to have clinical validity. Consult with physician for confirmation and initiate necessary physician documentation.

Physician involvement in this part of the assessment process is crucial. The physician should be asked to review the items in Section I at the time of visit closest to the scheduled MDS assessment. Use this scheduled visit as an opportunity to ensure that active diagnoses are noted and "inactive" diagnoses are designated as resolved. This is also an important opportunity to share the entire MDS assessment with the physician. In many nursing facilities physicians are not brought into the MDS review and assessment process. It is the responsibility of facility staff to aggressively solicit physician input. Inaccurate or missed diagnoses can be a serious impediment to care planning. Thus, you should share this section of the MDS with the physician and ask for his or her input. Physicians completing a portion of the MDS assessment should sign in Item R2 (Signatures of Those Completing the Assessment).

Full physician review of the most recent MDS assessment or ongoing input into the assessment currently being completed can be very useful. For the physician, the MDS assessment completed by facility staff can provide insights that would have otherwise not been possible. For staff, the informed comments of the physician may suggest new avenues of inquiry, or help to confirm existing observations, or suggest the need for additional follow-up.

Check a disease item only if the disease has a relationship to current ADL status, cognitive status, behavior status, medical treatment, nursing monitoring, or risk of death. For example, it is not necessary to check "hypertension" if one episode occurred several years ago unless the hypertension is either currently being controlled with medications, diet, biofeedback, etc., or is being regularly monitored to prevent a recurrence.

Coding: Do not record any conditions that have been resolved and no longer affect the resident's functional status or care plan.

Check all that apply. If none of the conditions apply, check *NONE OF ABOVE*. ***If you have more detailed information available in the clinical record for a more definitive diagnosis than is provided in the list in Section I1, check the more general diagnosis in I1 and then enter the more detailed diagnosis (with ICD-9-CM code) under I3.***

For example: If the record reveals that the resident has "osteoarthritis" you check item I11 (Arthritis) and record "Osteoarthritis" with 1CD-9-CM Code 715.00 in Section I3.

Consult the resident's transfer documentation (in the case of new admissions or re-admissions) and current medical record including current nursing care plans. There will be times when a particular diagnosis will not be documented in the medical record. If that is the case, as indicated above, accept statements by the resident that seem to have clinical validity, consult with the physician for confirmation, and initiate necessary physician documentation.

For example: If a new resident says he or she had a severe depression and was seeing a private psychiatrist in the community, this information may have been missed if the information was not carried forward in records accompanying the resident from an acute care hospital to the nursing home.

The following chart of ICD-9-CM codes for diseases listed in Item I1 is intended to clarify the level of specificity represented when the disease item is checked. This is also the list to use in computer applications of the MDS.

ICD-9-CM Codes for Diseases Listed in Section I1

ICD-9-CM Code	Disease Condition
ENDOCRINE/METABOLIC/NUTRITIONAL	
250.00	Diabetes mellitus
242.9[0 or1]	Hyperthyroidism
244.9	Hypothyroidism
HEART/CIRCULATION	
414.00 through 414.03	Arteriosclerotic heart disease (ASHD)
427.9	Cardiac dysrhythmia
428.0	Congestive heart failure
453.8	Deep vein thrombosis
401.9	Hypertension (unspecified)
458.9	Hypotension (unspecified)
443.9	Peripheral vascular disease (unspecified)
429.2	Other cardiovascular disease
MUSCULOSKELETAL	
716.90	Arthritis (unspecified site)
820.9	Hip fracture (unspecified site or NOS [not otherwise specified])
736.89	Missing limb (e.g., amputation)
733.00	Osteoporosis (unspecified)
733.10.	Pathological bone fracture (unspecified sites)

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ICD-9-CM Codes for Diseases Listed in Section I1
(Continued)

ICD-9-CM Code	Disease Condition
NEUROLOGICAL	
331.0	Alzheimer's disease
784.3	Aphasia
343.90	Cerebral palsy (unspecified)
436	Cerebrovascular accident (stroke) (NOS acute)
290.0	Dementia other than Alzheimer's (Senile Dementia, NOS)
342.90 through 342.92	Hemiplegia/Hemiparesis
340	Multiple sclerosis (NOS)
344.1	Paraplegia
332.0	Parkinson's disease
344.00 through 344.09	Quadriplegia
780.3	Seizure disorder
435.9	Transient ischemic attack (TIA) (unspecified)
854.00	Traumatic brain injury (unspecified)
PSYCHIATRIC/MOOD	
300.00	Anxiety disorder (unspecified)
311	Depression
296.8	Manic depression (bipolar disease)
295.90	Schizophrenia (unspecified)
PULMONARY	
493.90	Asthma (unspecified)
492.8	Emphysema
496	COPD
SENSORY	
366.9	Cataracts (unspecified)
362.01, 362.02 and 250.50 through 250.53	Diabetic retinopathy
365.9	Glaucoma (unspecified)
362.50	Macular degeneration (unspecified)
OTHER	
995.3	Allergies (unspecified)
285.9	Anemia
199.1	Cancer (unspecified as to site or stage)
586	Renal failure (unspecified)

ICD-9-CM: The International Classification of Diseases – 9th Revision – Clinical Modification. Ann Arbor, Michigan: Edward Brothers, Inc., October, 1989.

2. Infections

Definition: **Antibiotic resistant infection** (e.g., Methicillin resistant staph) — An infection in which bacteria have developed a resistance to the effective actions of an antibiotic. Check this item only if there is supporting documentation in the clinical record (including transmittal records of new admissions and recent transfers from other institutions).

Clostridium difficile (C.diff) — Diarrheal infection caused by the Clostridium difficile bacteria. Check this item only if there is supporting documentation in the clinical record of new admissions and recent transfers (e.g., hospital referral or discharge summary, laboratory report).

Conjunctivitis — Inflammation of the mucous membranes lining the eyelids. May be of bacterial, viral, allergic, or traumatic origin.

HIV infection — Check this item only if there is supporting documentation or the resident (or surrogate decision-maker) informs you of the presence of a positive blood test result for the Human Immunodeficiency Virus or diagnosis of AIDS.

Pneumonia — Inflammation of the lungs; most commonly of bacterial or viral origin.

Respiratory infection — Any upper or lower (e.g., bronchitis) respiratory infection other than pneumonia.

Septicemia — Morbid condition associated with bacterial growth in the blood.

Sexually transmitted diseases — Check this item only if there is supporting documentation of a current diagnosis of gonorrhea, or syphilis. DO NOT include HIV in this category.

Tuberculosis — Includes residents with active tuberculosis or those who have converted to PPD positive tuberculin status and are currently receiving drug treatment (e.g., isoniazid (INH), ethambutol, rifampin, cycloserine) for tuberculosis.

Urinary tract infection — Includes chronic and acute symptomatic infection(s) in the last 30 days. Check this item only if there is current supporting documentation and significant laboratory findings in the clinical record.

Viral hepatitis — Inflammation of the liver of viral origin. This category includes diagnoses of hepatitis A, hepatitis B, hepatitis non-A non-B, and hepatitis C.

Wound infection — Infection of any type of wound (e.g., surgical; traumatic; pressure) on any part of the body.

Process: Consult transfer documentation and the resident's clinical record (including current physician treatment orders and nursing care plans). Accept statements by the resident that seem to have clinical validity. Consult with physician for confirmation and initiate necessary physician documentation.

Physician involvement in this part of the assessment process is crucial.

Coding: Check an item only if the infection has a relationship to current ADL status, cognitive status, mood and behavior status, medical treatment, nursing monitoring, or risk of death. Do not record any conditions that have been resolved and no longer affect the resident's functional status or care plan. For example, do not check "tuberculosis" if the resident had TB several years ago unless the TB is either currently being controlled with medications or is being regularly monitored to detect a recurrence.

Check all that apply. If none of the conditions apply, check *NONE OF ABOVE*. If you have more detailed information available in the clinical record for a more definitive diagnosis than is provided in the list in Section I2 check the appropriate box in I2 and enter the more detailed information (with ICD-9-CM code) under I3.

ICD-9-CM Codes for Diseases Listed in Section I2

ICD-9-CM Code	Disease Condition
INFECTION	
041.9 or 041.11 or 041.19	Antibiotic resistant infection (e.g., methicillin resistant staph)
040.0	Clostridium difficile (C.diff)
372.30	Conjunctivitis
042	HIV infection
486	Pneumonia (organism unspecified)
038.9	Septicemia (not otherwise specified)
099.9	Sexually transmitted diseases (Venereal diseases) (unspecified)
011.90	Tuberculosis (pulmonary unspecified)
599.0	Urinary tract infection (site not specified)
070.9	Viral hepatitis (unspecified, without mention of hepatic coma)
958.3 or 998.5	Wound infection

ICD-9-CM: The International Classification of Diseases – 9th Revision – Clinical Modification. Ann Arbor, Michigan: Edward Brothers, Inc., October, 1989.

3. Other Current Diagnoses and ICD-9-CM Codes

Intent: To identify conditions not listed in Item I1 and I2 that affect the resident's current ADL status, mood and behavioral status, medical treatments, nursing monitoring, or risk of death. Also, to record more specific designations for general disease categories listed under I1 and I2.

Coding: Enter the description of the diagnoses on the lines provided. For each diagnosis, an ICD-9-CM code must be entered in the boxes to the right of the line. If this information is not available in the medical records, consult the most recent version of the full set of volumes of ICD-9-CM codes.

The person assigned to enter these codes should be trained in the ICD-9-CM assignment system. The task is best completed by a member of the medical record staff or the facility's medical record consultant. The person entering the ICD-9-CM codes must also enter his or her signature under MDS item R2, indicating that these codes were entered. The most recently updated version of the International Classification of Diseases - 9th Revision - Clinical Modification (ICD-9-CM) must be used. Volumes 1 and 2 of ICD-9-CM can be ordered from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. Specify order number S/N 9176–014-000000-1. Facilities do not need to order Volume 3, which classifies surgical, diagnostic, and nonsurgical procedures.

SECTION J.
HEALTH CONDITIONS

1. Problem Conditions

To record specific problems or symptoms that affect or could affect the resident's health or functional status, and to identify risk factors for illness, accident, and functional decline.

INDICATORS OF FLUID STATUS — It is often difficult to recognize when a frail, chronically ill elder is experiencing fluid overload that could precipitate congestive heart failure, or alternatively dehydration. Ways to monitor the problem, particularly in residents who are unable to recognize or report the common symptoms of fluid variation, are as follows:

Definition: **Weight gain or loss of 3 or more pounds within a 7-day period** — This can only be determined in residents who are weighed in the same manner at least weekly. However, the majority of residents will not require weekly or more frequent weights, and for these residents you will be unable to determine whether there has been a 3 or more pound gain or loss. When this is the case, leave this item blank.

Inability to lie flat due to shortness of breath — resident is uncomfortable lying supine. Resident requires more than one pillow or having the head of the bed mechanically raised in order to get enough air. This symptom often occurs with fluid overload. If the resident has shortness of breath when not lying flat, also check item J11 "Shortness of breath." If the resident does not have shortness of breath when upright (e.g., O.K. when using two pillows or sitting up) do not check item J11.

Dehydrated; output exceeds intake — check this item if the resident has 2 or more of the following indicators.

- Resident usually takes in less than the recommended 2500 ml of fluids daily (water or liquids in beverages, and water in food).
- Resident has clinical signs of dehydration.
- Resident's fluid loss exceeds the amount of fluids he or she takes in (e.g., loss from vomiting, fever, diarrhea that exceeds fluid replacement).

Insufficient fluid; did NOT consume all/almost all liquids provided during last 3 days — Liquids can include water, juices, coffee, gelatins, and soups.

OTHER

Delusions — Fixed, false beliefs not shared by others that the resident holds even when there is obvious proof or evidence to the contrary (e.g., belief he or she is terminally ill; belief that spouse is having an affair; belief that food served by the facility is poisoned).

Dizziness/vertigo — The resident experiences the sensation of unsteadiness, that he or she is turning, or that the surroundings are whirling around.

Edema — Excessive accumulation of fluid in tissues, either localized or systemic (generalized). Includes all types of edema (e.g., dependent, pulmonary, pitting).

Fever — Rectal temperatures above 100°Fahrenheit (38°Celsius) are considered significant in an elderly nursing home population. Many frail elders have normally low rectal baseline temperatures (e.g., 96° to 99°F). A fever is present when the resident's temperature (°F) is 2.4 degrees greater than the baseline temperature.

Hallucinations — False perceptions that occur in the absence of any real stimuli. A hallucination may be auditory (e.g., hearing voices), visual (e.g., seeing people, animals), tactile (e.g., feeling bugs crawling over skin), olfactory (e.g., smelling poisonous fumes), or gustatory (e.g., having strange tastes).

Internal bleeding — Bleeding may be frank (such as bright red blood) or occult (such as guaiac positive stools). Clinical indicators include black, tarry stools, vomiting "coffee grounds", hematuria (blood in urine), hemoptysis (coughing up blood), and severe epistaxis (nosebleed).

Recurrent lung aspirations in last 90 days — Note the extended time frame. Often occurs in residents with swallowing difficulties or who receive tube feedings (ie. esophageal reflux of stomach contents). Clinical indicators include productive cough, shortness of breath, wheezing. It is not necessary that there be X-ray evidence of lung aspiration for this item to be checked.

Shortness of breath — Difficulty breathing (dyspnea) occurring at rest, with activity, or in response to illness or anxiety. If the resident has shortness of breath while lying flat, also check item J1b ("Inability to lie flat due to shortness of breath.").

Syncope (fainting) — Transient loss of consciousness, characterized by unresponsiveness and loss of postural tone with spontaneous recovery.

Unsteady gait — A gait that places the resident at risk of falling. Unsteady gaits take many forms. The resident may appear unbalanced or walk with a sway. Other gaits may have uncoordinated or jerking movements. Examples of unsteady gaits may include fast gaits with large, careless movements; abnormally slow gaits with small shuffling steps; or wide-based gaits with halting, tentative steps:

Vomiting — Regurgitation of stomach contents; may be caused by any etiology (e.g., drug toxicity; influenza; psychogenic).

Process: Ask the resident if he or she has experienced any of the listed symptoms in the last seven days. Review the clinical records (including current nursing care plan) and consult with facility staff members and the resident's family if the resident is unable to respond. A resident may not complain to staff members or others, attributing such symptoms to "old age." Therefore, it is important to ask and observe the resident, directly if possible, since the health problems being experienced by the resident can often be remedied.

Coding: Check all conditions that occurred within the past seven days unless otherwise indicated (i.e. lung aspirations in the last 90 days). If no conditions apply, check *NONE OF ABOVE*.

2. Pain Symptoms

Intent: To record the frequency and intensity of signs and symptoms of pain. For care planning purposes this item can be used to identify indicators of pain as well as to monitor the resident's response to pain management interventions.

Definition: **Pain** — For MDS assessment purposes, pain refers to any type of physical pain or discomfort in any part of the body. Pain may be localized to one area, or may be more generalized. It may be acute or chronic, continuous or intermittent (comes and goes), or occur at rest or with movement. The pain experience is very subjective; pain is whatever the resident says it is.

Shows evidence of pain — depends on the observation of others (i.e., cues), either because the resident does not verbally complain, or is unable to verbalize.

Process: Ask the resident if he or she has experienced any pain in the last seven days. Ask him/her to describe the pain. If the resident states he or she has pain, take his or her word for it. Pain is a subjective experience. Also observe the resident for indicators of pain. Indicators include moaning, crying, and other vocalizations; wincing or frowning and other facial expressions; or body

posture such as guarding/protecting an area of the body, or lying very still; or decrease in usual activities.

In some residents, the pain experience can be very hard to discern. For example, in residents who have dementia and cannot verbalize that they are feeling pain, symptoms of pain can be manifested by particular behaviors such as calling out for help, pained facial expressions, refusing to eat, or striking out at a nurse assistant who tries to move them or touch a body part. Although such behaviors may not be solely indicative of pain, but rather may be indicative of multiple problems, code for the frequency and intensity of symptoms if in your clinical judgement it is possible that the behavior could be caused by the resident experiencing pain.

Ask nurse assistants and therapists who work with the resident if the resident had complaints or indicators of pain the last week.

Coding: Code for the highest level of pain present in the last seven days. If the resident has no pain, code "0", (No pain) and then Skip to item J4.

a. **Frequency** — How often the resident complains or shows evidence of pain.

Codes:
0. **No pain (Skip to item J4)**
1. **Pain less than daily**
2. **Pain daily**

b. **Intensity** — The severity of pain as described or manifested by the resident.

Codes:
1. **Mild pain** — Although the resident experiences some ("a little") pain he or she is usually able to carry on with daily routines, socialization, or sleep.

2. **Moderate pain** — Resident experiences "a medium" amount of pain.

3. **Times when pain is horrible or excruciating** — Worst possible pain. Pain of this type usually interferes with daily routines, socialization, sleep.

Use your best clinical judgement when coding. If you have difficulty determining the exact frequency or intensity of pain, code for the more severe level of pain. ***Rationale:*** Residents having pain will usually require further evaluation to determine the cause and to find interventions that promote comfort. You never want to miss an opportunity to relieve pain.